Gentle Care Dental

"Come in, sit back, and RELAX"

www.AZGentleCare.com

We would like to welcome you to our office!

If you have any questions or need assistance, please ask us, we will be happy to help!

Today's Date: _____

PATIENT INFORMATION (Confidential) Social Security # _____

Patient's Name: _____ Preferred Name: _____

Address: _____

Home Phone: _____ Cell: _____ Work: _____

May we contact you at your work number? □ Yes □ No

E-mail: _____ DOB: _____ □Single □ Married □ Minor

If patient is a minor, parents' names: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact (local) that does not live with you: _____

Phone: _____Relationship: _____

Who may we thank for referring you to us? (How did you hear about us?)_____

INSURANCE INFORMATION:

Insurance Company: _____ Ins Phone #: _____

ID #: _____ Group #: _____

Person Responsible for Account: _____

Relationship to Patient: _____ DOB: _____ Soc Sec #_____

DENTAL HISTORY

Who is your former dentist? _____ Phone: _____

Last cleaning, exam, or dental visit? _____ Date of last dental x-rays: _____

What is the reason for today's visit? _____

Are there any other concerns about your dental health? _____

_____

Do you have any medical problems which require taking antibiotics prior to dental work? □ Yes □ No

Please check if you have any:

□ Tooth sensitivity to cold

□ Tooth sensitivity to heat

□ Tooth sensitivity to sweets

□ Tooth sensitivity to biting

□ Jaw pain or fatigue

□ Previous orthodontic treatment

□ Bleeding gums

□ Blisters on lips/mouth

□ Burning sensation on tongue

□ Grinding or clenching jaw/teeth

□ Frequent headaches

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis/records of any treatment or examination rendered to me or my legal dependent to third party payers or other health practitioners. I authorize and request my insurance pay directly to Gentle Care Dental PLLC.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

HEALTH HISTORY

English

Patient Name:_____ Patient Identification Number:_____

Birth Date:_____

I. CIRCLE APPROPRIATE ANSWER (leave Blank if you do not understand question):

1. Yes No Is your general health good?
2. Yes No Has there been a change in your health within the last year?
3. Yes No Have you been hospitalized or had a serious illness in the last three years?
   If YES, why?_____
4. Yes No Are you being treated by a physician now? For what? _____
   Date of last medical exam?_____Date of last Dental exam_____
5. Yes No Have you had problems with prior dental treatment?
6. Yes No Are you in pain now?

II. HAVE YOU EXPERIENCED:

7. Yes No Chest pain (angina)?
8. Yes No Swollen ankles?
9. Yes No Shortness of breath?
10. Yes No Recent weight loss, fever, night sweats?
11. Yes No Persistent cough, coughing up blood?
12. Yes No Bleeding problems, bruising easily?
13. Yes No Sinus problems?
14. Yes No Difficulty swallowing?
15. Yes No Diarrhea, constipation, blood in stools?
16. Yes No Frequent vomiting, nausea?
17. Yes No Difficulty urinating, blood in urine?
18. Yes No Dizziness?
19. Yes No Ringing in ears?
20. Yes No Headaches?
21. Yes No Fainting spells?
22. Yes No Blurred vision?
23. Yes No Seizures?
24. Yes No Excessive thirst?
25. Yes No Frequent urination?
26. Yes No Dry mouth?
27. Yes No Jaundice?
28. Yes No Joint pain, stiffness?

III. DO YOU HAVE OR HAVE YOU HAD:

29. Yes No Heart disease?
30. Yes No Heart attack, heart defects?
31. Yes No Heart murmurs?
32. Yes No Rheumatic fever?
33. Yes No Stroke, hardening of arteries?
34. Yes No High blood pressure?
35. Yes No Asthma, TB, emphysema, other lung diseases?
36. Yes No Hepatitis, other liver disease?
37. Yes No Stomach problems, ulcers?
38. Yes No Allergies to: drugs, foods, medications, latex?
39. Yes No Family history of diabetes, heart problems, tumors?
40. Yes No AIDS
41. Yes No Tumors, cancer?
42. Yes No Arthritis, rheumatism?
43. Yes No Eye diseases?
44. Yes No Skin diseases?
45. Yes No Anemia?
46. Yes No VD (syphilis or gonorrhea)?
47. Yes No Herpes?
48. Yes No Kidney, bladder disease?
49. Yes No Thyroid, adrenal disease?
50. Yes No Diabetes?

IV. DO YOU HAVE OR HAVE YOU HAD:

51. Yes No Psychiatric care?
52. Yes No Radiation treatments?
53. Yes No Chemotherapy?
54. Yes No Prosthetic heart valve?
55. Yes No Artificial joint?
56. Yes No Hospitalization?
57. Yes No Blood transfusions?
58. Yes No Surgeries?
59. Yes No Pacemaker?
60. Yes No Contact lenses?

V. ARE YOU TAKING:

61. Yes No Recreational drugs?
62. Yes No Drugs, medications, over-the-counter medicines (including Aspirin), natural remedies?
63. Yes No Tobacco in any form?
64. Yes No Alcohol?

Please list:_____

_____

VI. WOMEN ONLY:

65. Yes No Are you or could you be pregnant or nursing?
66. Yes No Taking birth control pills?

VII. ALL PATIENTS:

67. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?

If so, please explain:_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

Patient's signature:_____ Date:_____

RECALL REVIEW:

1. Patient's signature_____ Date:_____
2. Patient's signature_____ Date:_____
3. Patient's signature_____ Date:_____

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APPOINTMENTS

Our team at Gentle Care Dental values your time as a patient. We ask for your help and effort in keeping with the schedule and being prompt to your given appointment time. We ask that you please give us at least **48 hour's notice** for any schedule changes. It is our commitment to extend the same courtesy by seeing our patients in a timely manner. However, due to unforeseen circumstances and emergencies, a slight wait may be possible. Thank you for your understanding and patience.

FOR YOUR PROTECTION

To serve you better, our office follows all OSHA guidelines in advanced sterilization technology for both staff and patients. Should you feel concerned about your protection or health, please do not hesitate to consult a member of our staff.

INSURANCE:

Dental insurance is one of the most beneficial and most misunderstood factors in dental treatment today. Dental insurance is a contract between the employer and the patient. It has no connection at all to the provider of your dental treatment. However, due to the various insurance plans available, we can only ESTIMATE your portion. Therefore, we request that you pay for your estimated portion when services are rendered. We allow 45 days from the date of service for the payment from your insurance carrier. Please remember that our contract for payment is with you, not your insurance carrier.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all changes in the office. All charges will be paid at the time services are rendered unless written financial agreements were made in advance. Patients with insurance coverage must sign a copy of the office policy on filling insurance claims and assignment of benefits. I understand that this office does not render services on the assumption that the charges will be paid by an insurance company. I agree to pay all late fees, collection cost (40%), attorney's fees, and any other costs that may be incurred to enforce collection of any outstanding amount. This office accepts cash, personal checks, Visa, Mastercard, Discover card. There is a return check fee of $35.00.

CONSENT FOR TREATMENT

I hereby authorize Gentle Care Dental to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Gentle Care Dental to perform all recommended treatment and to administer the appropriate medications or anesthetics mutually agreed on. I understand that using anesthetic agents is optional and using them involves certain risks, such as but not limited to, hematoma, parenthesis, allergic reactions, or increased heart rate. I will be given an opportunity to discuss any concerns or questions that I may have.

By signing below, I have read and I am in understanding of the policies above and agree to adhere to these policies as stated above by Gentle Care Dental PLLC.

Signature:_____ **Date:**_____

Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name_____
(Please Print)

Signature _____

Birthdate _____

Date_____